Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
SOUTHWESTERN ULTRASOUND
DBA DESERT IMAGING
118 W CASTELLANO
EL PASO TX 79912

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-05-2578-01

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 54

MFDR Received Date
DECEMBER 6, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim denied for no pre-auth but adjustor had informed us that no preauth was needed – how is the facility (us) suppose to know that a previous test was done when we are just providing services that are being requested?!"

Amount in Dispute: $4,752.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This carrier respectfully requests the Commission dismiss this request for dispute resolution for this date of service in dispute. The requestor did not request reconsideration of dates of service in dispute BEFORE requesting dispute resolution as required per TWCC Rule 133.304(m). TWCC Rule 133.304(k) states, 'If the sender of the bill is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit the request for reconsider…the request shall include:… (1) making o fthe [sic] complete medical bill that the health care provider is requesting the insurance carrier to reconsider, (A) clearly marked with the statement 'REQUEST FOR RECONSIDERATION'…' …(3) a claim-specific substantive explanation that enables the insurance carrier to understand the sender's position. This explanation shall rebut the insurance carrier's reason for its action as indicated on the explanation of benefits. A generic statement that simple states a conclusion such as 'insurance carrier improperly reduced the bill' or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.'… The requester alleges 'adjustor had informed us that no preauth was needed'. This carrier has no documentation that supports the requester's allegation that this carrier was contacted requesting preauthorization or inquiring regarding the need for preauthorization."

Response Submitted by: Texas Mutual Insurance Co., 221 W. 6th St., Ste. 300, Austin, TX 78749

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2004	CPT Codes 72158, 3600, 90784 HCPCS Code A4647	$4,752.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.304 sets out the procedures for medical payments and denials.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 13, 2004:
   - A – Preauthorization required by not requested.
   - 1* 03 – This procedure requires prior authorization. Repeat MRI. Previous study done on 5/6/03.
   - G – Unbundling.
   - Z3 – The procedure, which is the component code, is considered integral to the successful completion of the comprehensive procedure. The procedure does not represent a separately identifiable, unrelated procedure.
   - 3* 03 – The procedure requires prior authorization. The service rendered in integral to a service requiring preauthorization was not sought or approval was not obtained for the required service, therefore, reimbursement is not allowed
   - AB – The payment for this service is always bundled into payment for other services. Medicare CCI edits apply.
   - U – Unnecessary treatment (without peer review).
   - YU – This service has been deemed unnecessary medical treatment based on a review of the claim file. Billing records, and/or written review protocols established for approximate health care treatment.

Issues

1. Did the requestor submit a request for reconsideration in accordance with 28 Texas Administrative Code §133.304?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.304(m)the sender of a medical bill may request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution) if the sender of a medical bill has requested reconsideration in accordance with this section. Review of the submitted documentation from the requestor does not contain convincing evidence, such as a USPS return received requested or a facsimile showing date and time request for reconsideration was sent to the insurance carrier.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 15, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.